Department of Veterans Affairs **VHA HANDBOOK 1006.1**
Veterans Health Administration **Transmittal Sheet**
Washington, DC 20420 **May 19, 2004**

PLANNING AND ACTIVATING COMMUNITY-BASED OUTPATIENT CLINICS

1. PURPOSE: This Veterans Health Administration (VHA) Handbook defines the procedures for planning and activating new Department of Veterans Affairs (VA) Community-based Outpatient Clinics (CBOCs) and establishes consistent planning criteria and standardized expectations for CBOC operations.

2. SUMMARY OF CHANGES: This VHA Handbook establishes consistent planning criteria and standardized expectations for CBOC operations. Policy, planning criteria and business plan format were updated to reflect Capital Asset Realignment for Enhanced Services (CARES) planning methodologies and consistency with the CARES National Plan.

3. RELATED ISSUES: VHA Directive 1006 (to be published).

4. RESCISSIONS: VHA Handbook 1006.1, dated April 11, 2003, is rescinded.

5. RESPONSIBLE OFFICE: The Deputy Under Secretary for Health for Operations and Management (10N) is responsible for the contents of this Handbook. Questions may be addressed to 202-273-5841.

6. RECERTIFICATION: This VHA Handbook is scheduled for recertification on or before the last working day of May 2009.

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PLANNING AND ACTIVATING COMMUNITY-BASED OUTPATIENT CLINICS

1. PURPOSE

This Veterans Health Administration (VHA) Handbook defines the procedures for planning and activating new Department of Veterans Affairs (VA) Community-based Outpatient Clinics (CBOCs) and establishes consistent planning criteria and standardized expectations for CBOC operations.

2. BACKGROUND

a. Over the past 9 years, VHA has transitioned from a hospital bed-based system of care to a more effective system rooted in ambulatory and primary care. CBOCs are an important component of the VA health care delivery system.

b. A CBOC is a health care site (in a fixed location) that is geographically distinct or separate from the parent medical facility. A CBOC can be a site that is VA-operated and/or contracted. A CBOC must have the necessary professional medical staff, access to diagnostic testing and treatment capability, and the referral arrangements needed to ensure continuity of health care for currently and potentially eligible veteran patients (see par. 6). A CBOC must be operated in a manner that provides veterans with consistent, safe, high-quality health care, in accordance with VA policies and procedures.

c. Since 1995, VHA has activated over 450 new CBOCs to more efficiently and effectively serve eligible veterans and provide care in the most appropriate setting. Evaluations have shown CBOCs to be effective in improving access to health care services for veterans and providing high quality care in a cost-effective manner. This Handbook retains the Veterans Integrated Service Network (VISN) as the focal point for CBOC planning, allowing decisions regarding needs and priorities to be made in the context of local market circumstances and veteran preferences; it creates uniform criteria and standards that must be met to ensure consistency nation-wide.

d. The establishment of clinics is subject to the development of CBOC business plans and application of national CBOC criteria, the appropriate VA Central Office approval and notification of Congress, the availability of funds within the VISN, and applicable Federal statutes and VA regulations.

e. The current legislative authorities relevant to establishing CBOCs are outlined in Paragraph 7. Public Law 104-262, the Veterans' Health Care Eligibility Reform Act, provides significantly enhanced sharing authority to VHA. This legislation authorizes VA to obtain health care resources by entering into contracts or other agreements with any health care facility, entity, or individual. Generally speaking, this authority may now be used to contract for primary care and/or for a CBOC.

f. CBOC planning and activation are subject to the methodologies that are used in VHA's Capital Asset Realignment for Enhanced Services (CARES) process. CARES is a data driven assessment to evaluate veterans' future health care needs, and the strategic realignment of capital assets and related resources to better serve the needs of veterans. CARES provides a mechanism to measure veteran access to care, as well as develop strategies to improve access in identified

markets. This approach is continued in VHA's annual strategic planning process.

3. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for establishing national standards and guidance regarding CBOC planning, approval, implementation, ongoing monitoring, and operations.

b. **VISN Director.** The VISN Director is responsible for:

(1) Planning and establishing CBOCs to provide veterans with quality health care in the most appropriate setting. Specifically, CBOC planning must be undertaken to meet the following national goals, i.e., to:

(a) Address CARES-approved recommendations and VHA strategic planning methodologies. Specifically, CBOC planning needs to address:

1. The impact the proposed site will have on the access standards for primary care-defined markets, and/or

2. The impact the proposed site will have on parent facility space deficits that were identified through the CARES process.

(b) Improve access for current users by placing CBOCs in those areas where current users must travel significant distances and/or endure excessive travel time to access care. ***NOTE:*** *VHA access standards and travel times need to be applied.*

(c) Improve access to care for veterans living in rural areas.

(d) Improve equity of access to veterans by targeting underserved areas with low Priority 1-6 market penetration. ***NOTE:*** *Public Law 104-262 requires VA to manage enrollment of veterans in accordance with a series of priorities. The priority levels range from 1-8, with level 1 being the highest priority for enrollment. The same services are available to all enrolled veterans.*

(e) Improve efficiency and cost-effectiveness of operations.

(f) Increase patient satisfaction by increasing access to services and reducing waiting times.

(2) Developing strategic plans for the delivery of health care services to veterans, including CBOCs, through the annual strategic planning process and as an outgrowth of the CARES process. Network strategic plans are to be based on:

(a) Network-wide analyses of current and projected veteran demographics. A VISN-wide analysis determines relative priorities and identifies areas where there is evidence of the greatest need. ***NOTE:*** *Plans to establish new clinics need to be referenced in the annual Network strategic plan and financial plan. It is not a requirement to specifically identify individual sites or name the town of the new location in the annual plan; a general description of the proposed location (i.e., county or contiguous counties) is sufficient.*

(b) Current and projected utilization patterns.

(c) Analysis of the impact of proposed sites upon existing sites of care, including those sites outside the VISN boundaries. ***NOTE:*** *VISNs may undertake joint clinic initiatives to serve veteran populations residing in areas near the boundaries between two VISNs. Proposals that would locate new clinics across boundaries or in close proximity to a VISN border must be agreed to by each affected VISN Director and documentation of such an agreement must be submitted with the CBOC business plan.*

(3) Utilizing the following VHA National CBOC Criteria for planning and prioritizing new CBOCs (see App. A). ***NOTE:*** *Criteria are reviewed annually and modified to be consistent with VHA Strategic Goals and Objectives.* These criteria address the:

(a) Approved VHA access standards.

(b) Space deficits at a parent facility.

(c) Distance of proposed site from existing VHA primary care sites. The proposed site, when addressing an identified access need, should be at least 30 minutes from an existing primary care site for urban and rural areas, and 60 minutes for highly rural and/or low population density areas. If the CBOC is proposed to address space deficits at a parent facility, the proposed site should be no more than 20 minutes from the parent facility serve existing users.

(d) Number of current Priority 1-6 users in the proposed market area (at least 1,300 users in a 3-year period).

(e) Priority 1-6 market penetration in the proposed market area (below 25 percent). Priority 1-6 veteran population of the market area for the proposed CBOC (greater than national average of 38 percent).

(f) Unique considerations (geographic, demographic, etc.) such as: targeted minority veteran populations (e.g., Native Americans, African Americans, etc.), geographic barriers, highly rural and/or low population density (≤20 civilians per square mile), medically underserved or health manpower shortage area, Department of Defense (DOD) sharing opportunity, or parking and transit issues for sites proposed to address space deficits at parent facilities).

(g) Strength of the overall business plan (e.g., analysis of need, appropriate use of data, appropriate services for population to be served, etc.).

(h) Resources and cost effectiveness of proposed site.

(i) Impact on specialty care waiting times at the parent or closest VHA facility.

(4) Developing business plans for CBOCs and submitting those plans for VA Central Office approval and Congressional endorsement. CBOC business plans must be submitted for review against national planning criteria and approval by VA Central Office for the following types of CBOCs:

(a) Proposed CBOC which will increase access to care.

(b) Proposed CBOC which addresses space deficits at a parent facility.

(c) Proposed CBOC which will replace a campus due to a CARES-identified realignment (i.e., campus will close and CBOC will move off campus).

(d) Proposed CBOC which will be under a VA- DOD sharing arrangement.

(e) A CBOC in which VA provides primary care services at a Vet Center where VA-staffed or contracted primary service providers are stationed in space, provided at an existing Vet Center, to facilitate community access to care.

NOTE: *Questions concerning sharing of current VA space may be directed to the Capital Asset Management and Planning Service (CAMPS) Office (182C), and all other questions related to enhanced sharing authority for health care resources may be directed to the VHA Medical Sharing Office (176B).*

(5) Developing business plans that address all the data elements in the required formats (see App. B, App. C, and App. D). If a CBOC is proposed to address only space issues at a parent facility, use business plan Format B (see App. C). At a minimum, the following data elements must be addressed within the business plans:

(a) A general description of the rationale for establishing the CBOC and the outcomes to be achieved.

(b) A discussion and analysis of the alternatives that were considered in establishing the CBOC (including descriptions of the cost effectiveness of each alternative considered).

(c) A detailed target market analysis and proposed workload projections for the CBOC. This must include new and existing users to the clinic and a breakdown of users by priorities (1-6 and 7-8).

(d) A description and/or listing of the major types of medical and non-medical health care services to be provided, including a description of either the use or justification for not using telehealth to improve access of veteran patients to specialty care.

(e) An analysis of the target population's mental health care needs and mechanisms to address identified needs.

(f) A discussion of the funding available to support the CBOC, including the VISN Chief Financial Officer's (CFO's) certification that the facility can maintain services given current budget scenarios.

(g) A listing and description of the full-time equivalent (FTE) staffing that will be allocated to support the CBOC and enable it to meet expected panel sizes and timeliness standards.

(h) A comprehensive listing and description of estimated clinic costs, including both start-up and recurring costs.

(i) An analysis of the CBOC's impact on primary care waiting times at the parent facility.

(j) An analysis of the CBOC's impact on specialty care waiting times at all referral sites.

(k) A contingency plan for how resource needs will be met, or workload limited, should new workload substantially exceed what was projected.

(l) A description of stakeholder involvement and input.

(m) A plan, with timelines, for implementing the CBOC once the proposal is approved.

(n) A description of how the VISN will evaluate, on a regular basis, whether the CBOC is achieving its overall goals and objectives.

(o) Funding CBOCs entirely from resources available to the facility or Network, while maintaining capacity for specialized programs and long-term care services. It is recognized that "new users" are inevitable when a new CBOC is activated. This being the case, caution needs to be exercised when planning for additional CBOCs in view of VA's constrained resources.

4. APPROVAL PROCESS

a. A business plan to establish a CBOC must be developed by the VISN in accordance with the format and data elements listed in Appendix B or Appendix C. A finalized lease or sharing agreement should not be developed prior to CBOC approval. However, the business plan must reflect the intent to comply with the legislative and policy requirements pertaining to the acquisition of leased space using applicable Federal Acquisition Regulations (FAR), as well as VA policies and procedures.

b. The business plan and summary sheet (electronic copies must be available), in the formats delineated in Appendix B, Appendix C, and Appendix D, need to be submitted to the Deputy Under Secretary for Health for Operations and Management, who is responsible for coordinating VA Central Office review and the application of National criteria, as follows:

(1) The Office of the Deputy Under Secretary for Health for Operations and Management reviews all CBOC business plans for adherence to policy and format, and coordinates the technical review by General Counsel and the Office of Asset Enterprise Management (OAEM).

(2) The Office of the Deputy Under Secretary for Health for Operations and Management convenes a review panel on a quarterly basis for the purpose of applying the national criteria (see App. A) and recommending CBOC business plans for approval to the Deputy Under Secretary for Health for Operations and Management. The review panel consists of a representative from the offices of: the Deputy Under Secretary for Health for Operations and Management, the Office of Policy and Planning (OP&P), the Office of Patient Care Services, the CFO, a Network Planner, and a Network Clinical Manager or CBOC Coordinator, or their designees.

(3) CBOCs that are approved by the review panel are presented to the National Leadership Board by the Deputy Under Secretary for Health for Operations and Management for information and approved by the Under Secretary for Health and the Secretary of Veterans Affairs. The Office of the Deputy Under Secretary for Health for Operations and Management then prepares the CBOC package for notification of the House and Senate Appropriations Subcommittees. ***NOTE:*** *Consistent with past practice, proposals are sent to OAEM for*

forwarding to the Appropriations Subcommittees for final clearance. The Office of the Deputy Under Secretary for Health for Operations and Management notifies the Network regarding completion of the process and, if Congressional comments are offered, confers as necessary, with the Under Secretary for Health and appropriate Network Director.

(4) Final documents submitted for approval (see par. 7) are subject to VA Central Office review under established regulations, including any proposed agreements to acquire the use of space or health care services above the applicable dollar thresholds. In general, non-competitive sharing agreements below $500,000 (including all option years) and competitive sharing agreements below $1.5 million (including all option years) may be executed without prior legal and technical review by VA Central Office. Regional Counsel must review sharing agreements below these dollar thresholds. Copies of all executed sharing agreements must be sent to the Medical Sharing Office (176) within 5 days of final signature.

5. MONITORING AND EVALUATION PROCESS

a. Networks are responsible for the ongoing monitoring of CBOCs and ensuring that consistent, quality care is delivered according to VA regulations, policies, and procedures. Networks are responsible for evaluating whether CBOCs are meeting their business purposes, and overall goals and objectives.

b. The Office of Quality and Performance (OQ&P) provides feedback on CBOC performance annually with regard to Clinical Indicators such as: Patient Satisfaction Surveys, Preventive Care, and Clinical Guidelines. ***NOTE:*** *Results of these surveys are made available through the OQ&P web page at http://vaww.oqp.med.va.gov/ and must be incorporated into the Network performance management system.*

c. The Deputy Under Secretary for Health for Operations and Management is responsible for developing a set of monitors (available on the VISN Support Service Center (VSSC) web page at: http://vssc.med.va.gov) for evaluating CBOC progress in the following areas:

(1) Number of visits.

(2) Number of primary care and mental health encounters.

(3) Unique veterans treated.

(4) Unique veterans treated who are new to the system.

(5) Unique veterans treated by priority level (1-6 and 7-8).

(6) Waiting times.

(7) CBOC costs (use the Decision Support System (DSS)).

NOTE: *These monitors may be enhanced over time, as additional data become available. The Deputy Under Secretary for Health for Operations and Management reviews CBOC performance and monitors with the Networks on a quarterly basis through the Network Performance Review process.*

d. In the process of evaluating CBOC performance, Networks may decide not to open a planned clinic or to close an operating clinic.

(1) Reasons for this decision might include:

(a) Ability to accommodate veterans from the service area at a different community-based site,

(b) Inability to contract for care in the community, and/or

(c) Inability to acquire adequate staffing or site accommodations.

(2) Prior to effecting a decision not to activate or to deactivate a CBOC, Networks must submit a brief justification to the Deputy Under Secretary for Health for Operations and Management providing an explanation, rationale, and summary of stakeholder comments.

(3) Based on the information provided in the justification, a report is submitted by the Under Secretary for Health through the VA Budget Office and OAEM to the Congressional Appropriations Committees for notification, prior to Network action. ***NOTE:*** *Subsequent to receiving approval, Networks must submit a formal request to deactivate the clinic station number.*

e. In the process of monitoring or evaluating CBOC performance, Networks may wish to establish an outreach clinic to an existing primary care site or use a non-VA telemedicine network in an effort to improve geographical access. An outreach clinic is defined as a part-time operation, operated by staff based at the parent CBOC or parent medical center. Prior to a decision to proceed with such plans, Networks must obtain approval from the Deputy Under Secretary for Health for Operations and Management. To obtain approval, a justification providing an explanation, rationale, and summary of stakeholder comments should be submitted. Approval will only be granted for areas that meet the distance criteria for highly rural areas specified in the national planning criteria.

f. In the process of monitoring or evaluating CBOC performance, Networks may wish to change the location of an existing CBOC, lease additional space for an existing CBOC, expand services at an existing CBOC, or change management models (e.g., VA-staffed or contract). Prior to a decision to proceed with such plans, Networks must notify and obtain approval from the Deputy Under Secretary for Health for Operations and Management. To obtain approval, a justification providing an explanation, rationale, and summary of stakeholder comments should be submitted.

6. MINIMUM STANDARDS FOR CBOC OPERATIONS

Veterans receive one standard of care at all VHA health care facilities; care at CBOCs must be consistent, safe, and of high quality, regardless of model (VA-staffed or contract). CBOCs are expected to comply with all relevant VA policies and procedures, including those related to quality, patient safety, and performance. The following outlines specific requirements that must be met at CBOCs:

a. **Services.** The scope of service at CBOCs varies, based on the type of clinic and

population served. At a minimum, CBOCs must provide primary care and mental health services, depending upon the number and needs of veterans in the designated service area.

(1) **Primary Care Services.** At a minimum, Primary Care services provide intake; initial assessment; health promotion (screening and counseling); disease prevention; management of acute minor illnesses and chronic bio-psychosocial conditions; pharmacotherapy management; physical examinations; primary care women's health; injections and immunizations; referrals for specialty, rehabilitation, and other levels of care; follow-up; overall care management; and patient and caregiver education.

(2) **Mental Health Services.** CBOCs, at a minimum, must provide the following services: screening and prevention for mental disorders, and diagnostic evaluation for mental illness and substance abuse; pharmacotherapy, psychotherapy and/or psychosocial counseling for mental disorders; and referral for inpatient or residential care, direct care, or access to consultation for special emphasis and/or complex problems (e.g., Post-traumatic Stress Disorder (PTSD), substance abuse treatment, sexual trauma counseling, and patient and/or family education). ***NOTE:*** *The provision of other specialized medical or mental health services, including telemedicine options, at a CBOC depends on the size and needs of the population served. The mechanism by which these services are provided depends on various considerations including the type of contract arrangements, availability of qualified VA staff, or VA's ability to hire specialists in that location. The parent facility must have the capability to provide necessary backup support for the CBOC and referral mechanisms for specialty care.*

b. **Staffing.** CBOCs must be staffed to address projected patient demand. CBOCs are to be structured and managed through primary care panels and are subject to current policy on VHA primary care panel size and staffing models.

c. **Quality Management.** One standard of care must be maintained at all VHA health care facilities, including CBOCs. The quality of care expected is independent of the model, site, or provider (i.e., VA-staffed or contracted care). At a minimum, CBOCs must be incorporated into the parent facility's Quality Management Program, which includes analyses of care at CBOCs and credentialing and privileging of licensed independent and dependent providers. Identified quality of care issues are addressed through the facility's Quality Management Program. VA-staffed CBOCs must meet the standards of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).

d. **Emergencies.** Each CBOC must have a local policy or standard operating procedure defining how health emergencies are handled, including mental health emergencies. CBOCs must maintain appropriate emergency response capability. Parent facilities are responsible for making a determination as to the type(s) of equipment (e.g., a crash cart, Automatic External Defibrillators (AED)) that need to be located at the CBOC sites through their standing Code or Cardio-pulmonary Resuscitation Committees. CBOCs that do not have Advance Cardiac Life Support trained providers, appropriate supplies, and/or a Code team, are required to have an AED at their site.

e. **Timeliness.** CBOCs must meet VHA facility timeliness goals in accordance with current VHA policy.

f. **Performance Measures.** CBOC visits are included in the quarterly data and/or abstraction process that supports VHA's Performance Measurement Program (PMP). CBOC patients are to be included in National and local patient satisfaction surveys.

g. **Patient Safety.** Adverse events at CBOCs must be reported to the parent facility's patient safety officer or risk manager; they must be disseminated through the patient Safety Reporting System to the Network and to the National Patient Safety Center in Ann Arbor, MI, as outlined in VHA Handbook 1050.1.

h. **Station Numbering.** CBOCs are required to have a unique five-digit station identifier for workload reporting purposes. In accordance with VHA policy, the Office of the Deputy Under Secretary for Health for Operations and Management requests assignment of new station numbers at the time that CBOCs are approved, and the parent facility requests activation of the assigned station number at least 30 days prior to the opening of the clinic.

i. **Workload Reporting.** All workload that occurs at CBOCs is entered in the Veterans Health Information System and Technological Architecture (VistA) databases and submitted to the Austin Automation Center (AAC) utilizing the CBOCs five-digit station identifier. As appropriate, based on available services, laboratory, pharmacy, and radiology packages are to be set up for the CBOC. CBOCs must utilize the Computerized Patient Record System (CPRS) to the maximum potential.

j. **Health Records.** See VHA Handbook 1907.1, Health Information Management and Health Records, for establishment and maintenance of CBOC health records.

k. **Cost Accounting.** All CBOC costs are to be reported through the Decision Support System (DSS); CBOCs need to be set up as separate departments in both the Account Level Budgeter (ALBC) and in the Department Cost manager (DCM). ***NOTE:*** *As a Core Financial Logistics System (FLS) is developed, CBOC cost accounting needs to seamlessly transition into new cost accounting systems*.

l. **Accessibility.** CBOCs must comply with the statutes and regulations applicable to individuals with disabilities, including special patient populations (e.g., the Americans with Disabilities Act).

m. **Regulatory and Accrediting Standards.** CBOCs must comply with relevant regulatory and accrediting standards with respect to general environmental safety including the Office of Safety and Health Administration (OSHA) and JCAHO.

n. **Patient Complaints.** Veterans who receive care at a CBOC must have their, or their family members,' complaints addressed in a convenient and timely manner in accordance with VHA Directive 1050.2. Responses to complaints must occur as soon as possible, but no longer than 7 days after the complaint is made. All patient complaints must be entered in the National Patient Complaint database.

o. **Contracting.** CBOC contracts must meet VHA requirements as outlined by the VHA Logistics Office (176) and the Office of Patient Care Services (11).

7. LEGAL AUTHORITIES FOR ESTABLISHING CBOC

a. **Contracting With Non-VA Health Care Providers.** CBOCs may be established by entering into sharing agreements or contracts with non-VA health care providers to provide certain services to eligible VA beneficiaries. The statutes authorizing such sharing agreements or contracts have specific limitations.

(1) **Title 38 United States Code (U.S.C.) § 8153.** This statute authorizes VA to obtain health care resources by entering into contracts or other agreements with any health care provider, other entity, or individual**.** This is a broad authority that, in general terms, may be used to contract for professional services alone, or for a comprehensive practice including the physical plant in which the services are provided, e.g., CBOC.

(a) The term "health care resource" includes hospital care and medical services (as those terms are defined in 38 U.S.C. Section 1701), any other health care service, and any health care support or administrative resource, as well as medical equipment and space.

(b) The term "health care providers" includes health care plans and insurers, and any organizations, institutions, other entities, or individuals who furnish health care resources.

(c) Health care resources may be obtained from any health care providers. To the extent that the resource is obtained from an institution affiliated with VA in accordance with 38 U.S.C. Section 7302, including medical practice groups and other entities associated with affiliated institutions, it may be obtained on a sole-source basis. ***NOTE:*** *However, to the extent that the resource is obtained from a source other than an affiliate or an entity associated with an affiliate, competition must be obtained unless an adequate sole-source justification exists (see VHA Directive 1660.1*).

(2) **Title 38 U.S.C. § 7409.** This statute authorizes VA to enter into contracts with schools and colleges of medicine, osteopathy, dentistry, podiatry, optometry, and nursing, and clinics and/or any other group or individual capable of furnishing scarce medical specialist services to VA facilities.

(a) Under the terms of this statutory provision, the services must be provided in a VA facility. Consequently, this authority cannot be used to enter into agreements to establish CBOCs using the facilities of the provider with whom VA intends to contract.

(b) Because of the greater flexibility provided under 38 U.S.C. Section 8153, VHA facilities need to consider using that authority instead of 38 U.S.C. Section 7409, to obtain the services of scarce medical specialists.

(3) **Title 38 U.S.C. § 8111.** This statute authorizes VA to enter into agreements with DOD for the sharing of health care resources.

(a) Agreements under this authority may be used to establish CBOCs at DOD facilities using DOD personnel, VA personnel, or a combination of DOD and VA personnel.

(b) The term "health care resource" is broadly defined by the statute to include hospital care, medical services, rehabilitative services and "any other health care service, and any health care

support or administrative resource." Under this statute, it is possible to provide virtually any kind of health care at CBOCs, including primary care.

(c) Reimbursement must be based upon a flexible methodology that takes into account local conditions and needs, and the actual costs to the providing agency.

(d) Proposed agreements must be submitted for approval to the Under Secretary for Health and to the Assistant Secretary of Defense for Health Affairs. ***NOTE:*** *Such proposals become effective on the 46th day after receipt by either official, unless it is approved or disapproved at an earlier date.*

b. **Establishing VA-Operated CBOCs.** VA may establish a new outpatient presence by placing VA employees at approved CBOC locations. These locations may be either VA-leased space or VA-owned space.

(1) **Authority for Acquisition of CBOCs by Lease.** All proposed CBOCs are considered "medically related space" and must be funded locally. Space must be acquired in accordance with all applicable Federal laws and regulations, as well as VA Directives and procedures, to include, but not limited to, Veterans Affairs Acquisition Regulations and VA Directive 7815 Acquisition of Real Property By Lease and By Assignment from General Services Administration (GSA). ***NOTE:*** *Per VA Directive 7815, concept papers for proposed CBOCs with anticipated leases over $300,000 should be submitted to the on-line Capital Asset Management Service (CAMS) system (http://vaww.va.gov/oaem/). Once a CBOC is approved and receives Congressional Endorsement, appropriate entries in the space and functional database should be made and request for an AC lease identifiers, etc., need to be initiated. Additional information on this process can be found in the VSSC Construction and Capital Asset Guidebook (http://vhaaacsps4/CapAssets/Portal%20Content/Announcements/CapitalAssetGuidebook7.9.03.pdf).*

(2) **Acquisition of CBOC by Sharing Agreement**

(a) Authority. All proposed CBOCs are considered "medical space" and must be funded locally. Space can be acquired, on a very limited basis, through a competitive sharing agreement or through a non-competitive sharing agreement with an affiliated medical school.

(b) Procedure

1. The Sharing Authority, under 38 U.S.C. Section 8153, is not to be used to acquire space for a CBOC, unless the term is for less than 6 months and is the space required while a lease is being finalized. Sharing authority does not provide VA sufficient property protections to operate a medical clinic and is only to be used as a temporary solution. If this temporary space requires minimal special purpose alterations, facilities are restricted to using non-reoccurring maintenance (NRM) funds only for any renovations to space under a sharing agreement. If minor or major construction funds are required then a lease is the required option.

2. All sharing agreements under $500,000 over the term of the agreement must receive the review and concurrence of Regional Counsel. All sharing agreements awarded non-competitively over $500,000 and awarded competitively over $1.5 million must be reviewed and

approved by VA Central Office, including the Medical Sharing Office, Acquisitions and Material Management, Office of General Counsel, and the Office of Patient Care Services.

8. REFERENCES

a. VA Circular 00-90-22.

b. M-1, Part I, Chapter 34, Section II, Change 34.

c. VA Directive 7815.

*Proposals that receive 12 or more points are recommended to the Policy Board for approval. Proposals that do not receive a pass in item **(A1)** will not be recommended for approval, regardless of how many points are received.*

PROPOSAL CRITERIA (OPTIONS A AND B)

CRITERIA	Points and/or Formula (P/F)	Total Points
Community-Based Outpatient Clinic (CBOC) is proposed to address only space issues (i.e., not geographic access) at parent facility.	Y=Use Criteria Option B N=Use Criteria Option A	N/A
CRITERIA Option A		
(A1) Overall strength of the CBOC proposal (e.g., proposal demonstrates analysis of need and alternatives and includes appropriate services given the population to be served; proposal includes appropriate data sources and planning methodologies and/or projections to determine veteran utilization and workload; proposal is certified by the Veterans Integrated Services Network (VISN) Chief Financial Officer (CFO). Demonstrates sufficient veteran population to support clinic in the out years).	P/F If proposal receives F, it will not be approved	P/F
(A2) CBOC is identified in the Capital Asset Realignment for Enhanced Services (CARES) National Plan	Y=2 N=0	2
(A3) Geographic Access: a. CBOC is located in a market with an access planning initiative or is proposed to replace a campus due to a realignment. b. CBOC is located a minimum of 30 minutes driving distance from existing Veterans Health Administration (VHA) primary care site for urban or rural areas (rural = 166 civilians or less per square mile) or 60 minutes for highly rural (highly rural = 20 or less persons per square mile) areas.	a. Y=1; N=0 b. Y=2; N = 0	3
(A4) Number of current Priority 1-6 (P1-6) users (seen in the Department of Veterans Affairs (VA) system in previous 3 complete fiscal years) from proposed market area = 1,300 and/or number of P1-6 enrollees = 1,600	Y = 2; N = 0	2
(A5) a. P1-6 market penetration is 25 percent or lower, as defined by: P1-6 current users (seen in the VA system in the previous 3 complete fiscal years (FYs) from defined market area, divided by the P1-6 veteran population. b. P1-6 veteran population is 38 percent or more of total veteran population of the market area for the proposed CBOC.	a. Y = 1; N = 0 b. Y = 1; N = 0	2
(A6) Unique considerations (geographic, demographic and other) such as: targeted minority veteran populations (e.g., Native Americans, African Americans, etc), geographic barriers, low population density (≤20 civilians per square mile), medically underserved or health manpower shortage area, Department of Defense (DOD) sharing opportunity.	Y = 1; N = 0	1
(A7) Cost effectiveness as measured by: a. Total additional costs to be absorbed with the establishment of a CBOC have been listed and are judged to be reasonably accurate; b. The most cost-effective alternative to establish and provide care in the CBOC has been chosen.	a. Y =1; N=0 b. Y=1; N=0	2
(A8) Waiting Times: a. The average specialty care waiting times for all seven specialty clinics targeted by VHA National Performance measures (audiology, cardiology, eye care, orthopedics, urology, gastroenterology, mental health) at facilities that will receive referrals <30 days. b. The CBOC provides specialty care (other than required mental health services)that address long waiting times at the parent facility or referral sites (>30 days next available for that specialty)	a. Y=1; N=0 b. Y=1; N=0	2

CRITERIA Option B	**Points and/or Formula (P/F)**	**Total Points Available**
(B1) Overall strength of the CBOC proposal (e.g., proposal demonstrates analysis of need and alternatives and includes appropriate services given the population to be served; proposal includes appropriate data sources and planning methodologies and/or projections to determine veteran utilization and workload; proposal is certified by VISN CFO. Demonstrates sufficient veteran population to support clinic in the out years).	P/F If proposal receives F, it will not be approved	P/F
(B2) CBOC is identified in CARES National Plan	Y=2; N=0	2
(B3) CBOC addresses an ambulatory care space gap at a facility	Y=2; N=0	2
(B4) CBOC will serve existing users from parent facility	Y=2; N=0	2
(B5) CBOC is located a maximum of 20 minutes driving distance from parent facility	Y=2;N=0	2
(B6) Cost effectiveness as measured by: a. Total additional costs to be absorbed with the establishment of a CBOC have been listed and are judged to be reasonably accurate; b. The most cost-effective alternative to establish and provide care in the CBOC has been chosen.	 a. Y=1; N=0 b. Y=1; N=0	 2
(B7) Unique considerations, such as limited parking at parent facility; poor public transit access to parent facility, DOD sharing agreement opportunities, etc.	Y=1; N=0	1
(B8) Proposal documents an ongoing effort to address space shortages at the parent facility (expanded hours, leasing of off-site space for non clinical services, etc)	Y=1; N=0	1
(B9) Three fiscal years of ambulatory care workload growth has been documented by the parent facility in the business plan.	Y=2; N=0	2

REQUIRED BUSINESS PLAN FORMAT A FOR PROPOSED COMMUNITY-BASED OUTPATIENT CLINIC (CBOC)

1. CLINIC PROPOSED BY: VETERANS INTEGRATED SERVICE NETWORK (VISN) # _____

2. FOR FURTHER INFORMATION CONTACT. (Name, address, telephone and fax number of person(s) to contact for additional information. The designated person(s) needs to be able to answer specific questions about the proposal.)

3. PROPOSED CLINIC LOCATION. The proposed location, such as county, town, or city. ***NOTE:*** *A specific street location should not be given because this implies pre-selection of the site.* If a proposal addresses more than one site, each site must be specifically identified. ***NOTE:*** *If the CBOC is proposed to address only space issues (i.e., not geographic access issues) at a parent facility, use Business Plan Format B (see App. C).*

4. DISTANCE IN MINUTES FROM NEAREST PRIMARY CARE SITE. ***NOTE:*** *The information presented here will be used to review the proposal against the planning review criteria # A3 in Appendix A.*

a. Distance from nearest primary care site to proposed site should be reported using Capital Asset Realignment for Enhanced Services (CARES) travel and/or access standards. The data source needs to be specified and attention paid to the Veterans Health Administration (VHA) national criteria on minimum driving distances *(see criteria # A3 in App. A).*

b. Identify closest Department of Veterans Affairs (VA) sites (either within or outside Network) and discuss the impact of proposed clinic on these sites.

5. BUSINESS PURPOSES, GOALS, AND EXPECTED OUTCOMES FROM ACTIVATING THIS CBOC. ***NOTE:*** *The information presented here will be used to review the proposal against the planning review criteria #A2 and A3 in Appendix A.*

Provide a general description of the rationale for establishing the clinic and the outcomes to be achieved. Describe the following:

a. Is the proposed CBOC approved in the CARES National Plan? If not, provide justification for establishing the clinic.

b. Is the proposed CBOC related to CARES-approved realignments? If so, provide the start date for lease, construction, and/or build out and opening as well as the planned dates for phase out of the realigned campus.

c. Is the catchment area where the proposed CBOC is to be located part of a market that was identified by CARES as requiring a Planning Initiative due to a gap in Access? ***NOTE:*** *A list of CARES Planning Initiatives can be found at the Veterans Integrated Service Network (VISN) Support Service Center (VSSC) website at http://vaww.vsscportal.med.va.gov/Cares/Portal/Reports/.*

d. Provide an explanation of how the proposed CBOC will increase enrollee access to primary care. What percentage of enrollees in the CARES market area is currently located within 30 minutes of a primary care site. ***NOTE:*** *VISN market area information can be found at VSSC website at http://vaww.vsscportal.med.va.gov/Cares/Portal/Reports/ under Reports, Supply or Demand, Access by Market.*

Table 5d. Percentage of Enrollees in Market Located within 30 Minutes of a Primary Care Site

Market	2001 baseline (%)	2012 Projection (%)	2022 Projection (%)

e. How the CBOC would improve access to care for high-priority enrolled veterans (Priorities 1-6) in underserved areas of the VISN.

f. How the CBOC would impact primary care and specialty care (as defined by VHA Performance Measures, e.g., audiology, cardiology, eye care, orthopedics, and urology, gastroenterology and mental health) clinic-waiting times at the closest VA sites including all referral sites, and/or the result in cost savings (e.g., obviate the need for construction, beneficiary travel, fee basis costs, etc.).

6. DISCUSSIONS AND ANALYSIS OF ALTERNATIVE APPROACHES TO DELIVERING NEEDED SERVICES

a. Describe why current VA assets cannot accommodate the needs of veterans who reside in this service area. Describe in specific terms what alternatives were considered, including any Department of Defense (DOD) sharing opportunities or Vet Center collaborations. For each option, list the specific pros and cons and provide a summary of cost comparisons for each alternative considered. If the proposal is for a capitated contract clinic, explain how the estimated rate was determined. State the preferred alternative and why it was selected. ***NOTE:*** *Vet Center collaborations need to be planned in conjunction with the Vet Center Team Leader to ensure that planned health care initiatives are consistent with the community-based readjustment counseling mission of the Vet Center Program.*

b. In describing each option, summarize the following CBOC costs (use template and specified data sources in par. 9) and workload for the first full year of operation:

c. Non-recurring start-up costs (amortize costs over the term of the lease),

d. Total recurring costs to include salary and benefits (VA-staffed model only), VA-leased space, on-site ancillary services or local contract costs, all-inclusive contractual services (contract model), and all other recurring costs,

e. Projected unique users if different for the alternatives proposed.

NOTE: *This is an evaluation factor for cost-effectiveness. The proposal needs to demonstrate that the most cost-effective alternative is the proposed option. If the more expensive option is chosen, provide an explanation and/or rationale.*

7. DEMOGRAPHIC ANALYSIS AND/OR PROJECTED WORKLOAD. Discuss target market analysis and proposed workload projections for the CBOC. At a minimum, the following data and information needs to be identified (additional data elements can be provided where useful):

a. **Proposed Primary Service Area.** Identify the proposed primary service area, i.e., county(ies), or zip code area(s) (when zip code data becomes available) to be served by CBOC. Explain how far the proposed service area is from an existing VA primary care facility. Primary service areas need to generally encompass no more than a 30-minute radius from the proposed CBOC site; in rural or highly rural areas, this can reasonably be increased to a 60-minute radius. If any, describe any unique geographic or transportation issues (e.g., land barriers, transportation limitations, etc.).

b. **Demographic Data.** Provide the following demographic data for the proposed service area:

(1) Current veteran population and a 5-year population projection, age distribution of veterans as outlined in the following Table 7b. In addition, describe any income or economic factors and/or minority veteran information, if pertinent. Demographic data (by national county lists, CARES market and Historical markets) is available on the VSSC website (http://vssc.med.va.gov/) under Reports/CBOC/CBOC Business Plan.

(2) **Format Table 7b**.

Current and Projected Veteran Population	County A or Zip Code Area A	County B or Zip Code Area B
2002		
2003		
2004		
2005		
2006		
2007		
2012		
Age Distribution: 0 – 44	%	%
45 – 64	%	%
≥ 65	%	%
Gender: Male	%	%
Female	%	%

c. **Market Penetration Analyses.** Provide market penetration information as follows: current veteran market penetration (number of users from last 3 complete Fiscal Years (FYs) divided by the veteran population = percentage of market penetration) within proposed service area.

(1) Provide user market penetration by County or zip code using the format displayed in Table 7c.1. This data in table format is available at the VSSC website (http://vssc.med.va.gov/) under Reports/CBOC/CBOC Business Plan. ***NOTE:*** *Report the veteran current market penetration within the proposed service area using the following formula: number of users from last 3 complete FYs divided by the veteran population = percentage of market penetration.*

(2) **Format Table 7c1.**

County, or Zip Code Area	Total Unique VA Users (last 3 FYs)	Total Veteran Population Latest FY	Total 3-year Market Penetration	Parent Facility Users (last 3 FYs)	Total 3-year Parent Facility Market Penetration
County A			%		%
County B			%		%
Total			%		%

(3) Provide the number and percent of veteran population users by priority level for the proposed service area. This data in table format is available at the VSSC website (http://vssc.med.va.gov/) under Reports/CBOC/CBOC Business Plan.

(4) **Format Table 7c2.**

Priority Group	Total VA Existing Users by Priority Group	Total Veteran Population By Priority Group	Market Penetration
1-6			%
7-8			%
Total (Priority 1-8)			

(5) Provide the percentage of the total veteran population for the proposed area that is Priority 1-6 (P1-6) veterans (e.g., for the entire proposed area calculate as follows: percentage of P1-6 veteran population = P1-6 veteran population of the proposed area divided by the total veteran population of the proposed area). This information can be found at http://vssc.med.va.gov/planning/marketpenetration2003d.asp#.

d. **User and Visit Data.** This paragraph needs to describe how many veterans will be served at the CBOC and what the anticipated visit workload will be. 'Existing veterans' (uniques) to be re-directed from parent facility as well as projected 'new veterans' need to be included. In addition, the number of visits expected (visits and/or unique) should be documented. Segment projected workload by new and existing unique users, and by priority level (1-6 and 7-8).

(1) As a guideline, the targeted increases need to be based on experience for CBOCs nationally (for reference see Historical Priority User Group Information Report located at http://152.125.187.140:8081/planning/Docs/Historical%20CBOC%20Information.xls and CBOC VAST Workload Report located at http://vssc.med.va.gov/planning/cboc/CBOC_report.asp) or within the VISN to date.

(2) CARES utilization projections for the counties that will be included in the CBOC market area also need to be factored in to the workload estimates. ***NOTE:*** *This data is available on the VSSC CARES Portal at http://vssc.med.va.gov.*

(3) Show workload (both unique users and visits), projected for a 3-year period, in a table similar to the one following, and explain the methodology used. Total Veteran VA Users by

County is available as baseline information at the VSSC's website http://vssc.med.va.gov/cboc/table7d.asp.

Format Table 7d.

	Start-up Year, or First Year	Second Year	Third Year
Total Existing Users a. Priority Group 1-6 b. Priority Group 7-8			
New Users b. Priority Group 1-6 c. Priority Group 7-8			
Total Users a. Priority Group 1-6 b. Priority Group 7-8			
Total Visits			

NOTE: *As a guideline, annual primary care visits per unique patient generally average three to three point five visits per unique. For CBOCs with basic mental health services available on site, visits per unique patient average four to five visits per unique patient.*

e. **Waiting Times Analysis.** For the parent facility and, if applicable, the other closest facility to the proposed CBOC, provide the specialty care waiting times as outlined in following Table 7e.

Table 7e. Specialty Care Waiting Times

Facility*	Average Specialty Care Waiting Times						
	Audiology	Eye	Urology	Cardiology	Orthopedics	GI	Mental Health
Facility A							
Facility B							
Facility C							

*Include all referring facilities
Data Source: This data in table format is available at the VSSC website (http://vssc.med.va.gov/) under Reports/CBOC/CBOC Business Plan

f. **Designations and/or Unique Considerations.**

(1) Describe whether this proposal is targeted to meet:

(a) The needs of underserved minority populations (e.g., Native Americans, African-Americans,

etc.). Describe the targeted minority veteran population (e.g., percentage of minority veteran population that will be served by the CBOC).

(b) The needs of veterans living in an officially designated Health Professional Shortage Area [refer to web page: http://bhpr.hrsa.gov/healthworkforce/ or a 'medically underserved' area based on other factors (e.g., population to physician ratio, percentage of people below poverty line, percentage 65 and older, and relative infant mortality rate). Specify the areas that are designated as Health Professional Shortage Areas or medically underserved and the percentage of veterans from these areas that will be served.

(c) The needs of veterans living in highly rural areas or areas of low population densities.

(2) Describe any other unique demographic and/or geographic considerations (mountainous or desert area, bodies of water, low population density, etc.). ***NOTE:*** *Attach maps if applicable.*

8. DESCRIPTION OF SERVICES TO BE PROVIDED

a. **Scope of Services**

(1) List types of medical (e.g., primary care, mental health services, pharmacy, electrocardiogram (EKG), etc.) and non-medical (e.g., social work, benefits counseling, etc.) health care services to be provided in this CBOC.

(2) Include a description of how access to ancillary services (laboratory, x-ray, pharmacy, etc.) will be provided, as well as specialty and consultative services if they will not be provided at the CBOC.

(3) Include a description of the use or justification for not using telehealth to improve access of veteran patients to specialty care. If telehealth will be employed, include information on the following: the clinical services under consideration; details of the associated information and telecommunications technology requirements; description of anticipated space which telehealth consultations/care can be provided (e.g., space that is adequately lit, soundproofed and private). ***NOTE:*** *Telehealth enables veteran patients to access specialty services e.g. specialist mental health, dermatology and surgery consultations from clinicians in secondary and tertiary care facilities thereby reducing waiting times and the cost and inconvenience of travel to veterans. Specific "toolkits" have been created by VHA to assist in establishing these telehealth-mediated services within a CBOC. Telehealth can also reduce the need for clinician traveling time to remote CBOC's and in doing so increase the availability of clinicians to provide consultations to veterans.*

(4) Discuss the lines of authority and/or accountability for the clinic operation.

(5) Describe the referral relationship between this CBOC and its "parent" medical center.

(6) Include a discussion of how the CBOC will handle after hours and emergency care in accordance with VHA policy.

NOTE: *It would be helpful to show what both VA and the Contractor will provide. This section needs to be very specific about how services such as x-ray, laboratory, pharmacy, mental health, etc., will be provided.*

b. **Mental Health Service Description.** Fully address how access to mental health services will be provided. Veterans seen at CBOCs need to have a convenient means for accessing minimum and additional mental health services if needed. In support of providing (or not providing) on-site mental health services, report results of the Network's Mental Health Needs Assessment Template, as needed.

c. **Specialty Care Needs Assessment**

(1) Describe how specialty services will be provided at the CBOC.

(2) Discuss how the provision of specialty services at the CBOC will address backlogs at referral facilities.

d. **Quality of Care Monitoring**

(1) Specifically address how CBOC quality of care will be monitored on a continuing basis (i.e., process to be used).

(2) Ensure that one standard of care is exhibited throughout the system.

9. CLINIC COSTS

a. **VISN Capacity for Funding of CBOC**

(1) Address the ability of the VISN to fund the CBOC within existing resources (Attach VISN Chief Financial Officer (CFO) certification indicating ability to fund CBOC within existing resources).

(2) Specify, as precisely as possible, the sources of funds and Full-time Equivalents (FTE) that will be used at the CBOC, and how CBOC costs will be absorbed in light of resource constraints. If new workload is anticipated, describe the planned approach to deal with this increased cost.

b. **Staffing and/or Projected Workload**

(1) Identify staffing (by number and type) in recurring cost Table 9d2.

(2) Address in table and narrative format how:

(a) Staffing will meet the projected workload,

(b) FTE will be modified should workload be higher than anticipated, and

(c) Staff absences will be covered. ***NOTE:*** *Clinical provider FTE (i.e., physicians, nurse practitioners, physician assistants) should reflect VHA panel size guidelines.*

c. **Specialized Treatment and Rehabilitative Needs of Disabled Veterans.** Address the potential impact of the proposed CBOC on the parent facility's ability to maintain capacity for the Specialized Treatment and Rehabilitative Needs of Disabled Veterans. Implementation of the CBOC must not draw resources away from this commitment.

d. **Following Annual Costs.** The following annual costs need to be included and portrayed in tabular form for the start-up year and the next 2 full fiscal years. ***NOTE:*** *Use these tables to provide information for each alternative considered and/or discussed in paragraph 6 of the business plan)*

Table 9d1. Non-recurring or Start-up Costs. (Provide details regarding any capital costs).

Non-recurring Costs	Total Cost
(1) Construction, lease build out, purchase, or renovation of space	$
(2) Equipment a. Clinical b. Computer c. Telecommunication	
(3) Furnishings	
(4) Permanent Change of Station (PCS) Moving Expense	
(5) Miscellaneous (specify if any single item is over $10,000)	
(6) Contract Start-up Fee (see footnote 1	
(7) Total non-recurring costs	$
(8) Annualized Life Cycle Capital and/or non-recurring Cost (see footnote 2)	$

1 If contract firms charge a start-up fee, include this cost here.
2 Formula and automatic calculations are built into a spreadsheet that can be downloaded from the VSSC website: http://vssc.med.va.gov/

Table 9d2. Recurring Costs

Recurring Costs	Start-up Year	Year 2	Year 3
(1) Salary cost, including benefits (total for VA-staffed model)			
(2) Real Property Lease (annual cost for VA-leased space)			
(3) *Additional radiology cost (done at or for CBOC including contract)			
(4) *Additional laboratory cost (done at or for CBOC including contract)			
(5) **Additional pharmacy cost (provided at or for CBOC including contract and Consolidated Mail Out Pharmacy (CMOP)			
(6) Additional specialty care costs (provided for the CBOC including at the parent facility, referral sites, or contract)			
(7) Contractual Services (all inclusive for contract model)**			
(8) Other Miscellaneous cost (e.g., utilities)			
(9) Total Projected Budget (sum of preceding items (1)-(8) plus item (8) from non-recurring costs in Table 9d.1	$	$	$

*Do not include costs for the services associated with existing patients being transferred from the parent or other facility to proposed CBOC.

**Do not include costs for prescriptions associated with existing patients being transferred from the parent or other facility to proposed CBOC. Take cumulative new unique patients expected to be seen at the CBOC each year and multiply by the expected

average prescriptions per patient. Multiply total prescriptions for each year by expected average cost per prescription. Base the estimates of expected average prescriptions per patient and expected average cost per prescription on experience in similar CBOCs in the VISN.

Recurring Costs	Start-up Year	Year 2	Year 3
(10) For VA-staffed clinics, number of FTE a. Medical Doctor (MD); Doctor of Osteopathic Medicine (DO) b. Registered Nurse Practitioner (RNP) c. Physician Assistant (PA) d. Registered Nurse (RN) e. Licensed Vocational Nurse (LVN) f. Other (Specify)			
(11) Projected Unique Patients			
(12) Projected Visits			
(13) Cost per Unique (item 9 divided by item 11)			
(14) Cost per Visit (item 9 divided by item 12)			

**Projected Contractual Cost equals inclusive annual contract cost per unique multiplied by the number of unique patients expected to be enrolled in the proposed CBOC. (Provide explanation of how annual contract cost per unique was estimated.)

e. Provide details regarding any lease costs; i.e., square feet of space required and estimated cost per square foot. For contract clinics, describe how costs were derived.

f. Provide details regarding cost avoidance (fee-basis, beneficiary travel, renovation and/or capital expenditures) and revenue.

Table 9f. Projected Cost Avoidance and/or Cost-Savings and Revenue

	Start-up Year	Year 2	Year 3
(1) Projected Cost Avoidance and/or Savings (specify in the following narrative)			
(2) Projected increases in Medical Care Collection Fund (MCCF) (based on parent facility MCCF collection rates)			
(3) Projected TRICARE, sharing or other non-MCCF revenues			
(4) Net Revenue Total*	$	$	$

*Net revenue=any revenue in excess of costs to treat non-VA patients. Attach methodology used.

g. Accurate and consistent accounting for costs at each CBOC is an important issue. Describe how accurate and consistent cost accountability for the CBOC will be ensured following activation. Specifically, a statement needs to be made acknowledging the need to report all CBOC costs through the Decision Support System (DSS).

10. CONTINGENCY PLAN FOR OVER-CAPACITY WORKLOAD

(1) Describe how 'new workload' at the CBOC will be limited or managed if it exceeds workload or budget projections. For example: resource and/or FTE shift from the parent facility, case management, increased use of telehealth technology, and other efficiencies.

(2) Describe how the potential impact of the CBOC workload on the parent facility's specialty clinics will be addressed (e.g., additional staff, community contracts, fee basis, sharing agreement, etc.).

11. STAKEHOLDER INVOLVEMENT REPORT

(1) Describe involvement and/or support of stakeholder groups in the service area of the proposed CBOC, as well as any future involvement anticipated for the CBOC. Outline, in

chronological format, what has been done, or is planned, with regard to notifying and involving stakeholders. Provide information on the type of meetings (e.g., town hall, Veterans Service Organizations, community forums, etc.), as well as feedback received.

(2) Identify, by name, the United States Senators, and the Congressional Districts and United States Congressmen whose districts (by number) will be a part of the CBOC service area.

12. IMPLEMENTATION PLAN. Detail the plans for implementing the clinic once the proposal is approved. Indicate the number of months it will take to open the CBOC following approval. Provide a timeline, not specific dates, for each of the processes and/or activities that need to occur in order for the CBOC to open. See the following suggested implementation plan:

Steps	Activities (will vary)	Timeline
1	Announce establishment of CBOC (stakeholder notification)	
2	Lease space (if applicable) a. Procure space b. Recruit staff c. Complete renovations and/or furnishings d. Train staff	
2	Contract activities (if applicable) a. Prepare solicitation for contract services b. Response time for proposals c. Evaluate proposals and select contractor d. Provide training and/or orientation	
3	Schedule opening date	
4	Patient scheduling	
5	Assess final CBOC needs	
6	CBOC Opening	

13. EVALUATION PLAN. Describe the parent facility's plan to regularly evaluate how the CBOC is achieving the business plan and overall goals and objectives discussed in the proposal. Discuss how the VISN will coordinate this effort to ensure that the same minimal criteria are used to evaluate CBOCs throughout the VISN. Include a discussion of specific performance measures, workload and cost parameters, and minimum thresholds to be used in managing the CBOC and assessing its effectiveness. At a minimum, CBOC monitoring should include VA performance measures, the number of visits, type of visits (primary care, mental health), unique veterans, new and existing users, Priority 1-6 and 7-8 users, waiting times, unit costs, and patient satisfaction.

14. NATIONAL CRITERIA SUMMARY. Attach a copy of the following table that provides the page # in the business plan where each of the planning criteria is addressed.

Criteria Option A	Page#
(A1) Overall strength of the CBOC proposal (e.g., proposal demonstrates analysis of need and alternatives and includes appropriate services given the population to be served; proposal includes appropriate data sources and planning methodologies and/or projections to determine veteran utilization and workload; proposal is certified by the Veterans Integrated Services Network (VISN) Chief Financial Officer (CFO). Demonstrates sufficient veteran population to support clinic in the out years).	N/A
(A2) CBOC is identified in the Capital Asset Realignment for Enhanced Services (CARES) National Plan	
(A3) Geographic Access: a. CBOC is located in a market with an access planning initiative or is proposed to replace a campus due to a realignment. b. CBOC is located a minimum of 30 minutes driving distance from existing Veterans Health Administration (VHA) primary care site for urban or rural areas (rural = 166 civilians or less per square mile) or 60 minutes for highly rural (highly rural = 20 or less persons per square mile) areas.	
(A4) Number of current Priority 1-6 (P1-6) users (seen in the Department of Veterans Affairs (VA) system in previous 3 complete fiscal years) from proposed market area = 1,300 and/or number of P1-6 enrollees = 1,600	
(A5) a. P1-6 market penetration is 25 percent or lower, as defined by: P1-6 current users (seen in the VA system in the previous 3 complete fiscal years (FYs) from defined market area, divided by the P1-6 veteran population. b. P1-6 veteran population is 38 percent or more of total veteran population of the market area for the proposed CBOC.	
(A6) Unique considerations (geographic, demographic and other) such as: targeted minority veteran populations (e.g., Native Americans, African Americans, etc), geographic barriers, low population density (≤20 civilians per square mile), medically underserved or health manpower shortage area, Department of Defense (DOD) sharing opportunity.	
(A7) Cost effectiveness as measured by: a. Total additional costs to be absorbed with the establishment of a CBOC have been listed and are judged to be reasonably accurate; b. The most cost-effective alternative to establish and provide care in the CBOC has been chosen.	
(A8) Waiting Times: a. The average specialty care waiting times for all seven-specialty clinics targeted by VHA National Performance Measures (audiology, cardiology, eye care, orthopedics, urology, gastroenterology, mental health) at facilities that will receive referrals <30 days. b. The CBOC provides specialty care (other than required mental health services)that address long waiting times at the parent facility or referral sites (>30 days next available for that specialty).	

15. DATA SOURCES. Use data from the latest completed fiscal year. Following are some suggested data sources; additional sources (i.e., zip code and specific data) are continually being added to these web pages.

a. VSSC/CBOC Business Plan Reports http://vssc.med.va.gov; Go to CBOC Reports/CBOC Business Plan.

b. Veteran population, by county, and by age group: http://vaww.pssg.med.va.gov/datamenu.asp.

c. Distributed Planning Population Database (DPPB) Model: http://vaww.pssg.med.va.gov/pcproducts.asp: "Facility Outpatient Utilization by County" for identifying market areas.

d. Veteran enrollees, by county, by zip code, and by priority group (1-6 and 7): http://vssc.med.va.gov; Go to CBOC Reports/CBOC Business Plan.

e. Enrollment Projections: http://vaww.vsscportal.med.va.gov/cares/.

f. Veteran users, by county and priority groups: http://vssc.med.va.gov; Go to CBOC Reports/CBOC Business Plan.

g. Veteran Historical User Information By Priority Group: http://152.125.187.140:8081/planning/Docs/Historical%20CBOC%20Information.xls and CBOC VAST Workload Report located at http://vssc.med.va.gov/planning/cboc/CBOC_report.asp.

h. CBOC workload database: http://vssc.med.va.gov/planning/cboc/CBOC_report.asp.

i. Designated Health Professional Shortage Areas: http://bhpr.hrsa.gov/healthworkforce/.

j. Medically Underserved Areas: http://bhpr.hrsa.gov/healthworkforce/.

k. Geographic distances between VA sites and between counties: Average distances (straight line), enrollees and users http://vaww.pssg.med.va.gov/datamenu.asp zip code data.

l. Cost data: available through local Decision Support System (DSS).

REQUIRED BUSINESS PLAN FORMAT B FOR COMMUNITY-BASED OUTPATIENT CLINIC (CBOC) PROPOSED ONLY TO ADDRESS SPACE DEFICITS AT A PARENT FACILITY

1. CLINIC PROPOSED BY: VETERANS INTEGRATED SERVICE NETWORK (VISN) # _____

2. FOR FURTHER INFORMATION CONTACT. (Name, address, telephone and fax number of person(s) to contact for additional information. The designated person(s) needs to be able to answer specific questions about the proposal.)

3. PROPOSED CLINIC LOCATION. The proposed location, such as county, town or city. ***NOTE:*** *A specific street location should not be given because this implies pre-selection of the site.* If a proposal addresses more than one site, each site must be specifically identified. ***NOTE:*** *Use this Business Plan format if the Community-based Outpatient Clinic (CBOC) is proposed to only address space deficits at a parent facility.*

4. DISTANCE IN MINUTES FROM NEAREST PRIMARY CARE SITE. ***NOTE:*** *The information presented here will be used to review the proposal against the planning review criteria #B5 in Appendix A).*

a. Distance from nearest primary care site to proposed site should be reported using the national criteria specified in Appendix A, Criteria Option B. Specifically, the proposed site should be a maximum of 20 minutes driving time from the parent facility. The data source needs to be specified.

b. Identify the closest Department of Veterans Affairs (VA) sites (either within or outside Network) and discuss the impact of proposed clinic on these sites.

5. BUSINESS PURPOSES, GOALS, AND EXPECTED OUTCOMES FROM ACTIVATING THIS CBOC. ***NOTE****: The information presented here will be used to review the proposal against the planning review criteria # B2-B4 in Appendix A.* Provide a general description of the rationale for establishing the clinic and the outcomes to be achieved. Describe the following:

a. Is the proposed CBOC approved in the Capital Asset Realignment for Enhanced Services (CARES) National Plan? If not, provide justification for establishing the clinic. ***NOTE:*** *A list of CARES Planning Initiatives can be found at Veterans Integrated Service Network (VISN) Support Service Center (VSSC) website at http://vssc.med.va.gov/.*

b. Describe how the proposed site will address space deficits at the parent facility. Include a discussion of all solutions employed to date to increase clinical space at the parent facility. (e.g., expanded hours, leasing of off-site space for non-clinical services, etc.).

c. Describe the plan to ensure that the proposed site would serve existing users from the parent facility.

d. Describe how the proposed site would impact primary care and specialty care (as defined by Veterans Health Administration (VHA) National Performance Measures, e.g., audiology,

cardiology, eye care, orthopedics, urology, gastroenterology and mental health) clinic waiting times at the parent site, and/or the result in cost savings (e.g., obviate the need for construction, beneficiary travel, fee basis costs, etc.). Describe if and how the site will provide specialty care.

6. DISCUSSION AND ANALYSIS OF ALTERNATIVE APPROACHES TO DELIVERING NEEDED SERVICES

a. Describe why current VA assets cannot accommodate the needs of veterans who currently are receiving care at the parent facility. Describe in specific terms what alternatives were considered. Describe all efforts to expand clinical space at parent facility (e.g., expanded hours of operations, leased space for non-clinical services, etc.). For each option, list the specific pros and cons and provide a summary of cost comparisons for each alternative considered. If the proposal is for a capitated contract clinic, explain how the estimated rate was determined. State the preferred alternative and why it was selected.

b. In describing each option, summarize the following CBOC costs (use template and specified data sources in par. 9) and workload for the first full-year of operation:

(1) Non-recurring start-up costs (amortize costs over the term of the lease).

(2) Total recurring costs to include salary and benefits (VA-staffed model only). Include VA-leased space, on-site ancillary services or local contract costs, all-inclusive contractual services (contract model), and all other recurring costs.

(3) Projected unique users, if different for the alternatives proposed.

NOTE: *This is an evaluation factor for cost-effectiveness. The proposal needs to demonstrate that the most cost-effective alternative is the proposed option. If the more expensive option is chosen, provide an explanation or rationale.*

7. DEMOGRAPHIC ANALYSES AND/OR PROJECTED WORKLOAD. Provide historical and proposed workload projections for the CBOC. At a minimum, the following data and information needs to be identified (additional data elements can be provided where useful):

a. **Existing Users.** Describe the trend of existing veteran users over the past three fiscal years (FYs) and current users to date. Provide the information in a table similar to following Table 7a: ***NOTE:*** *Priority Group 1-6 is P1-6, and Priority Group 7-8 is P7-8.*

Table 7a. Existing Veteran User Trends

Existing Parent Facility Users	FY 2001	FY 2002	FY 2003	FY 2004 (to date)
P1-6				
P7-8				

b. **Ambulatory Care Workload.** Describe the ambulatory care workload at the parent facility for the previous three FYs and the FY to date. Provide the information in a table similar to following Table 7b:

Table 7b. Workload Trends

Total Outpatient Visits	**FY 2001**	**FY 2002**	**FY 2003**	**FY 2004 (to date)**
Parent Facility Name				

c. **Projected User and Visit Data.** This paragraph needs to describe how many existing veterans (uniques) will be re-directed from the parent facility and the anticipated workload. The number of visits expected (visits and/or unique) should be documented. Segment projected workload by new and existing unique users, and by P1-6 and P7-8.

(1) Show workload (both unique users and visits), projected for a 3-year period, in a table similar to the one following, and explain the methodology used. Total Veteran VA Users by County is available as baseline information at the VSSC's website http://vssc.med.va.gov/cboc/table7d.asp.

(2) Format Table7c1.

Table 7c.1 Projected User and Visit Data

	Start-up Year, or First Year	**Second Year**	**Third Year**
Total Existing Users a. Priority Group 1-6 b. Priority Group 7-8			
	Start-up Year, or First Year	**Second Year**	**Third Year**
Total Visits			

NOTE: *As a guideline, annual primary care visits per unique patient generally average three to three point five visits per unique. For CBOCs with basic mental health services available on site, visits per unique patient average four to five visits per unique patient.*

d. **Designations and/or Unique Considerations.** Describe whether this proposal is targeted to address:

(1) The needs of underserved minority populations (e.g., Native Americans, African-Americans, etc.). Describe the targeted minority veteran population (e.g., percentage of minority veteran population that will be served by the CBOC).

(2) Parking issues at parent facility.

(3) Public transit access issues.

8. DESCRIPTION OF SERVICES TO BE PROVIDED

a. **Scope of Services**

(1) List types of medical (e.g., primary care, mental health services, pharmacy, electrocardiogram (EKG), etc.) and non-medical (e.g., social work, benefits counseling, etc.) health care services to be provided in this CBOC.

(2) Include a description of how access to ancillary services (laboratory, x-ray, pharmacy, etc.) will be provided, as well as specialty and consultative services, if they will not be provided at the CBOC.

(3) Discuss the lines of authority and/or accountability for the clinic operation.

(4) Describe the referral relationship between this CBOC and its "parent" medical center.

(5) Include a discussion of how the CBOC will handle after hours and emergency care in accordance with VHA policy.

NOTE: *It would be helpful to show what both VA and the Contractor will provide. This section needs to be very specific about how services, such as x-ray, laboratory, pharmacy, mental health, etc., will be provided.*

b. **Mental Health Service Description.** Fully address how access to mental health services will be provided. Veterans seen at CBOCs need to have a convenient means for accessing minimum and additional mental health services, if needed. In support of providing (or not providing) on-site mental health services, report results of the Network's Mental Health Needs Assessment Template, as needed.

c. **Specialty Care Needs Assessment**

(1) Describe how specialty services will be provided at the CBOC.

(2) Discuss how the provision of specialty services at the CBOC will address backlogs at referral facilities.

d. **Quality of Care Monitoring**

(1) Specifically address how CBOC quality of care will be monitored on a continuing basis (i.e., the process to be used).

(2) Ensure that one standard of care is exhibited throughout the system.

9. CLINIC COSTS

a. **VISN Capacity for Funding of CBOC**

(1) Address the ability of the VISN to fund the CBOC within existing resources. (Attach VISN Chief Financial Officer (CFO) certification indicating ability to fund CBOC within existing resources).

(2) Specify, as precisely as possible, the sources of funds and Full-time Equivalents (FTE) that will be used at the CBOC, and how CBOC costs will be absorbed in light of resource constraints. If new workload is anticipated, describe the planned approach to deal with this increased cost.

b. **Staffing and/or Projected Workload**

(1) Identify staffing (by number and type) in recurring cost Table 9d2.

(2) Address in table and narrative format how:

(a) Staffing will meet the projected workload,

(b) FTE will be modified should workload be higher than anticipated, and

(c) Staff absences will be covered. ***NOTE:*** *Clinical provider FTE (i.e., physicians, nurse practitioners, physician assistants) needs to reflect VHA panel size guidelines.*

c. **Specialized Treatment and Rehabilitative Needs of Disabled Veterans.** Address the potential impact of the proposed CBOC on the parent facility's ability to maintain capacity for the Specialized Treatment and Rehabilitative Needs of Disabled Veterans. Implementation of the CBOC must not draw resources away from this commitment.

d. **Following Annual Costs.** The following annual costs need to be included and portrayed in tabular form for the start-up year and the next 2 full-fiscal years. ***NOTE:*** *Use these tables to provide information for each alternative considered and/or discussed in paragraph 6 of the business plan.*

Table 9d1. Non-recurring or Start-up Costs. (Provide details regarding any capital costs).

Non-recurring Costs	Total Cost
(1) Construction, lease build out, purchase, or renovation of space	$
(2) Equipment a. Clinical b. Computer c. Telecommunication	

Non-recurring Costs	Total Cost
(3) Furnishings	
(4) Permanent Change of Station (PCS) Moving Expense	
(5) Miscellaneous (specify if any single item is over $10,000)	
(6) Contract Start-up Fee (see footnote 1)	
(7) Total non-recurring costs	$
(8) Annualized Life Cycle Capital/non-recurring Cost (see footnote 2)	$

1 If contract firms charge a start-up fee, include this cost here.
2 Formula and automatic calculations are built into a spreadsheet that can be downloaded from the VSSC website: http://vssc.med.va.gov/

Table 9d2. Recurring Costs

	Start-up Year	Year 2	Year 3
(1) Salary cost, including benefits (total for VA-staffed model)			
(2) Real Property Lease (annual cost for VA-leased space)			
(3) *Additional radiology cost (done at or for CBOC, including contract)			
(4) *Additional laboratory cost (done at or for CBOC, including contract)			

*Do not include costs for the services associated with existing patients being transferred from the parent or other facility to proposed CBOC.

(5) **Additional pharmacy cost (provided at or for CBOC including contract and Consolidated Mail Out Pharmacy (CMOP)			
(6) Additional specialty care costs (provided for the CBOC including at the parent facility, referral sites, or contract)			
(7) Contractual Services (all inclusive for contract model)***			
(8) Other Miscellaneous cost (e.g., utilities)			
(9) Total Projected Budget (sum of preceding items (1)-(8) plus item (8) from non-recurring costs in Table 9d1	$	$	$
(10) For VA-staffed clinics, number of FTE a. Medical Doctor (MD); Doctor of Osteopathic Medicine (DO) b. Registered Nurse Practitioner (RNP), c. Physician Assistant (PA) d. Registered Nurse (RN) e. Licensed Vocational Nurse (LVN) f. Other (Specify)			

**Do not include costs for prescriptions associated with existing patients being transferred from the parent or other facility to proposed CBOC. Take cumulative new unique patients expected to be seen at the CBOC each year and multiply by the expected average prescriptions per patient. Multiply total prescriptions for each year by expected average cost per prescription. Base the estimates of expected average prescriptions per patient and expected average cost per prescription on experience in similar CBOCs in the VISN.

*** Projected Contractual Cost equals inclusive annual contract cost per unique multiplied by the number of unique patients expected to be enrolled in the proposed CBOC. (Provide an explanation of how annual contract cost per unique was estimated.)

Table 9d2. Recurring Costs continued	Start-up Year	Year 2	Year 3
(11) Projected Unique Patients			
(12) Projected Visits			
(13) Cost per Unique (item 9 divided by item 11)			
(14) Cost per Visit (item 9 divided by item 12)			

e. Provide details regarding any lease costs; i.e., square feet of space required and estimated cost per square foot. For contract clinics, describe how costs were derived.

f. Provide details regarding cost avoidance (fee-basis, beneficiary travel, renovation and/or capital expenditures) and revenue.

Table 9f. - Projected Cost Avoidance and/or Cost-Savings and Revenue

	Start-up Year	Year 2	Year 3
(1) Projected Cost Avoidance and/or Savings (specify in the following narrative)			
(2) Projected increases in Medical Care Collection Fund (MCCF) (based on parent facility MCCF collection rates)			
(3) Projected Tricare, sharing or other non-MCCF revenues			
(4) Net Revenue Total*	$	$	$

*Net revenue=any revenue in excess of costs to treat non-VA patients. Attach methodology used.

g. Accurate and consistent accounting for costs at each CBOC is an important issue. Describe how accurate and consistent cost accountability for the CBOC will be ensured

following activation. Specifically a statement needs to be made acknowledging the need to report all CBOC cost through the Decision Support System (DSS).

10. CONTINGENCY PLAN FOR OVER-CAPACITY WORKLOAD.

a. Describe how 'new workload' at the CBOC will be limited or managed if it exceeds workload or budget projections; for example: resource and/or FTE shifts from the parent facility, case management, increased use of telehealth technology, and other efficiencies.

b. Describe how the potential impact of the CBOC workload on the parent facility's specialty clinics will be addressed (e.g., additional staff, community contracts, fee basis, sharing agreement, etc.).

11. STAKEHOLDER INVOLVEMENT REPORT.

a. Describe involvement and/or support of stakeholder groups in the service area of the proposed CBOC, as well as any future involvement anticipated for the CBOC. Outline, in chronological format, what has been done, or is planned, with regard to notifying and involving stakeholders. Provide information on the type of meetings (e.g., town hall, Veterans Service Organizations, community forums, etc.), as well as feedback received.

b. Identify the United States Senators, and the Congressional Districts and Congressmen (by name) whose districts (by number) will be a part of the CBOC service area.

12. IMPLEMENTATION PLAN. Detail the plans for implementing the clinic once the proposal is approved. Indicate the number of months it will take to open the CBOC following approval. Provide a timeline, not specific dates, for each of the processes and/or activities that need to occur in order for the CBOC to open. See the following suggested implementation plan:

Steps	Activities (will vary)	Timeline
1	Announce establishment of CBOC (stakeholder notification)	
2	Lease space (if applicable) a. Procure space b. Recruit staff c. Complete renovations and/or furnishings d. Train staff	

Steps	Activities (will vary)	Timeline
2	Contract activities (if applicable) a. Prepare solicitation for contract services b. Response time for proposals c. Evaluate proposals and select contractor d. Provide training and/or orientation	
3	Schedule opening date	
4	Patient scheduling	
5	Assess final CBOC needs	
6	CBOC Opening	

13. EVALUATION PLAN. Describe the parent facility's plan to regularly evaluate how the CBOC is achieving the business plan and overall goals and objectives discussed in the proposal. Discuss how the VISN will coordinate this effort to ensure that the same minimal criteria are used to evaluate CBOCs throughout the VISN. Include a discussion of specific performance measures, workload and cost parameters, and minimum thresholds to be used in managing the CBOC and assessing its effectiveness. At a minimum, CBOC monitoring needs to include VA performance measures, the number of visits, type of visits (primary care, mental health), unique veterans, new and existing users, P1-6 and P7-8 users, waiting times, unit costs, and patient satisfaction.

14. NATIONAL CRITERIA SUMMARY. Attach a copy of the following table that provides the page number in the business plan where each criteria are addressed.

Criteria Option B	Page #
(B1) Overall strength of the Community-based Outpatient Clinic (CBOC) proposal (e.g., proposal demonstrates analysis of need and alternatives and includes appropriate services given the population to be served; proposal includes appropriate data sources and planning methodologies and/or projections to determine veteran utilization and workload; proposal is certified by Veterans Integrated Services Network (VISN) Chief Financial Officer (CFO). Demonstrates sufficient veteran population to support clinic in the out years).	N/A
(B2) CBOC is identified in Capital Asset Realignment for Enhanced Services (CARES) National Plan	
(B3) CBOC addresses an ambulatory care space gap at the facility	
(B4) CBOC will serve existing users from parent facility	
(B5) CBOC is located a maximum of 20 minutes driving distance from parent facility	
(B6) Cost effectiveness as measured by: a. Total additional costs to be absorbed with the establishment of a CBOC have been listed and are judged to be reasonably accurate; b. The most cost-effective alternative to establish and provide care in the CBOC has been chosen.	
(B7) Unique considerations, such as limited parking at parent facility; poor public transit access to parent facility; Department of Defense (DOD) sharing agreement opportunities, etc.	
(B8) Proposal documents an ongoing effort to address space shortages at the parent facility (expanded hours, leasing of off-site space for non-clinical services, etc)	
(B9) Three fiscal years of ambulatory care workload growth has been documented by parent facility in business plan.	

15. DATA SOURCES. Use data from the latest completed fiscal year. Following are some suggested data sources; additional sources (i.e., zip code and specific data) are continually being added to these web pages.

a. VSSC/CBOC Business Plan Reports http://vssc.med.va.gov; Go to CBOC Reports/CBOC Business Plan.

b. Veteran population, by county, and by age group: http://vaww.pssg.med.va.gov/datamenu.asp.

c. Distributed Planning Population Database (DPPB) Model: http://vaww.pssg.med.va.gov/pcproducts.asp: "Facility Outpatient Utilization by County" for identifying market areas.

d. Veteran enrollees, by county, by zip code, and by priority group (1-6 and 7): http://vssc.med.va.gov; Go to CBOC Reports/CBOC Business Plan.

e. Enrollment Projections: http://vaww.vsscportal.med.va.gov/cares/.

f. Veteran users, by county and priority groups: http://vssc.med.va.gov; Go to CBOC Reports/CBOC Business Plan.

g. Veteran Historical User Information By Priority Group: http://152.125.187.140:8081/planning/Docs/Historical%20CBOC%20Information.xls and CBOC VAST Workload Report located at http://vssc.med.va.gov/planning/cboc/CBOC_report.asp).

h. CBOC workload database: vssc.med.va.gov/planning/cboc/CBOC report.asp.

i. Designated Health Professional Shortage Areas: http://bhpr.hrsa.gov/healthworkforce/.

j. Medically Underserved Areas: http://bhpr.hrsa.gov/healthworkforce/.

k. Geographic distances between VA sites and between counties: Average distances (straight line), enrollees and users http://vaww.pssg.med.va.gov/datamenu.asp zip code data.

l. Cost data: available through local Decision Support System (DSS).

INSTRUCTIONS FOR COMPLETING COMMUNITY-BASED OUTPATIENT CLINIC (CBOC) SUMMARY SHEET

NOTE: *This summary is the only paper going to Congress and requires strict adherence to standardization of format. The font must be Arial 12. Adhere to the format provided which should be limited to one page in length and includes using tables to provide information in following paragraphs 3 and 9. Only provide that information which is absolutely essential. Each of the twelve section headings on the Summary Sheet needs to be in bold, with the information and/or data provided in regular print.*

1. Proposed Location. Provide county or counties, not specific city or town. Specify Community-based Outpatient Clinic (CBOC**)** service area.

2. Parent Facility. Self-explanatory.

3. List of Other Approved CBOCs Under Parent Facility Jurisdiction. Needs to be in table format; provide month and year.

CBOC Location(s)	Approval Date	Opening Date

4. Congressional Districts (identify the district and the name representative(s). Include all the names of the Senators from the associated state (s) and United States Congressmen whose districts are part of the service area.

5. Projected Opening Date. Do not give the exact date. Project the number of months it will take to open, subsequent to approval. Be realistic. The expectation is for all clinics to be open within 1 year of approval.

6. Type of Care to be Provided. Indicate if Primary Care and/or Primary Mental Health Care Services or other specialty care services are to be provided.

7. Type of Arrangement. For example:

a. VA-staffed in leased space.

b. Contract.

c. Sharing space with contractor to provide health care services.

8. Projected Start-up Cost (total one-time and non-recurring). The one-time start-up cost.

9. Projected Annual Operating Budget and Workload (for the first full fiscal year of operation). This needs to be in a table format; see the following example:

Salary	$
Real Property Rentals	$
Radiology	$
Laboratory	$
Pharmacy	$
Specialty Care	$
Contractual Services	$
Other Miscellaneous	$
Total Projected Budget	$
Full-time Equivalent (FTE)	
Projected Patients***** Existing (1-6, 7-8) New (1-6, 7-8)	
Projected Visits	
Cost per Visit	$

*****Projected Patients. Need to give separate numbers for both existing and new patients that will add up to Projected Patients. Both existing and new needs to be broken out by Priority 1-6, and Priority 7-8, as follows: New Users (1-6 and 7-8), Existing Users (1-6 and 7-8).

10. Estimated Cost Savings. This information is, or should, already be provided in the proposal.

BENEFICIARY TRAVEL _____ FEE BASIS _____ OTHER (identify) _____

11. Will the new CBOC Address an Underserved Population? This refers to whether the area to be served is designated in the Federal Register as a medically underserved area. A simple Yes or No is sufficient without any detailed explanation.

12. Is the Proposed CBOC Listed in the Most Recent Veterans Integrated Service Network (VISN) Strategic Plan submission? A simple Yes or No is sufficient.